METROPOLITAN DADE COUNTY
ACCIDENTAL DEATH INSURANCE

☐ Change of Beneficiary
☐ Change of Name
Former Name
☐ Other

Name of Employer	Department	Division

Name of Employee (Last, First, Middle)	Date of Birth

Social Security No.	Occupation

Name of Beneficiary (Last, First, Middle)	Relationship to Employee

Date

Signature of Employee

INSTRUCTIONS – DISTRIBUTION: White/Department — Blue/Employee — **Yellow/Central Personnel Files**
Send white copy to Insurance Management Division in the event of on-the-job death of employee.

160.C5-36 Rev. 11/82